CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/24/2011		
	PROVIDER OR SUPPLIER	L & REHABILITATIVE CENTER	p. wir	STREET A	DDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F0000	This visit was Complaint IN(for Investigation of 00086241.	F00	000			
	Complaint IN(Unsubstantiate evidence.	00086241 - ed due to lack of					
	Unrelated defi	ciencies cited.					
	Survey date: 2	2/24/11					
	Census bed ty	per: 155561 100273920 Jennie Bartelt, RN					
	SNF/NF: 79 Total: 79						
	Census payor Medicare: 12 Medicaid: 44 Other: 23 Total: 79						
	Sample: 3						
	V DIRECTORIS OR BROX	/INED/CIIDDI IED DEDDECENTATIVE'C CI		!	TITI E		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8T311

Facility ID:

000327

PRINTED: 03/25/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561			(X2) MULTIPLE CC A. BUILDING B. WING	JNS1 RUCTION	COMP 02/24/2	LETED
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	STREET 231 N 3	ADDRESS, CITY, STATE, ZIP COE JACKSON ST AND CITY, IN47660	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG	These deficient findings cited 410 IAC 16.2.	cies also reflect state in accordance with	TAG	DEFICIENCY)		DATE

000327

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLI	
		155561	B. WIN			02/24/20	J11
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	AMARITAN HOME	& REHABILITATIVE CENTER			ND CITY, IN47660		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0280	Based on obse	rvation, interview,	F02	80	F-280 Right to Participate		03/16/2011
SS=D		iew, the facility			Planning Care – Revise CP		
		e a plan of care was			What corrective action(s) will be	e	
		nong family and			accomplished for those residents		
		acility care providers			found to have been affected by t deficient practice?	the	
	-	plan related the			-		
	-	ing techniques was			Resident D: The Care Plan has be		
		e. The deficient			updated to ensure plan of care wa coordinated among family and sta		
	-	ed 1 of 1 resident			Direct Care staff and family were	;	
	_	ed to a swallowing			immediately in serviced by Speed Therapist regarding swallowing	ch	
	problem and s	· ·			instructions for feeding of pureed		
	techniques in a	_			diet and thickened liquids per MI		
	•	•			order.		
	residents (Res	,			How other residents having the		
	Findings inclu	de:			potential to be affected by the same deficient practice will be		
					identified and what corrective		
		ew on 2/24/11 at 1:00			action(s) will be taken?		
	•	mily member of			Audit will be completed on all		
		ne indicated she was			Residents to ensure ordered diet i correct. Speech Therapist will in	s	
	-	daily from morning			service Clinical staff on any speci	ial	
	•	eed the resident her			feeding techniques that is identifi	ed	
		ep everything moving			with audit. Audit will be comple by DNS/ADNS/DESIGNEE BY	ted	
	- beverages co	ld, food warm." At			03-15-211.		
		dent D was observed			A dia iii h		
	seated at the b	edside in a high			Audit will be completed on Aide Assignment sheets to ensure orde	red	
	backed chair v	vith a neck pillow in			diet and special feeding precaution		
	place. The far	mily member used			are correct. To be completed by DNS/ADNS/DESIGNEE BY		
	small white plastic spoons to spoon			03-15-11.			
	small amounts	of pureed foods to					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	DING		COMPLETED	
		155561	B. WIN			02/24/2	011	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF	ę.		231 N J	JACKSON ST			
		& REHABILITATIVE CENTER			ND CITY, IN47660			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEI (CLERCI)		DATE	
	the resident.				What measures will be put into			
	beverages wer	re observed to be			place or what systematic change	es l		
	thickened. Th	ne family member			will be made to ensure that the			
		egular staff make			deficient practice does not recur	?		
	sure the reside	ent's foods are pureed			Clinical Nurses/Speech Therapist			
		s moving. She			will be in serviced to notify Speed			
					Therapy and Dietary of all diets u			
		'new ones have to			admission, readmission and chang	ge		
	learn - they wa	ant to give her regular			in condition.			
	water with ice	2."			In service to be completed by DNS/ADNS/Designee by			
					03-15-2011			
	 The clinical re	ecord for Resident D						
					IDT team to ensure that special d	iets		
	was reviewed	on 2/24/11 at 4:00			or residents with special feeding			
	p.m.				precautions are communicated to			
					Speech Therapy and dietary will review all New Admissions and			
	The record inc	dicated the resident			Readmits/residents with change is	n		
	 was readmitte	d to the facility on			condition. Care Plan will be			
		ving hospitalization			updated and Aide Assignment Sh			
		• •			will be updated at that time. Morn	ning		
		diagnoses including,			IDT Clinical meeting.			
		d to, hypoxia and			Clinical Nurses/Speech Therapist			
	pneumonia. A	A Speech Pathology			will be in serviced to notify Speed			
	Report of Mod	dified Barium			Therapy and Dietary of all diets u	^		
	1 *	S), dated 1/26/11,			admission, readmission and chang	ge		
	,	was not limited to,			in condition. In service to be completed by			
					DNS/ADNS/Designee by			
		Pt [patient] requires			03-15-2011			
	strict adherence	ce to swallow						
	strategies to m	ninimize risk for			Speech Therapist/Designee will in			
	aspiration." "	Swallowing			service to inform the Clinical Statupon Admission/readmission/cha			
	1 ^	cluded, "Position			in condition to ensure safety and	nge		
		1010000, 1 00101011			special precautions are followed.	To		
					- ^			

Facility ID:

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155561		LDING		02/24/2011	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/2 1/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	JACKSON ST		
		& REHABILITATIVE CENTER		1	ND CITY, IN47660		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
1110		mbol for degrees]		1710	be completed by	BINE	
	during and 30	[minutes] after			DNS/ADNS/Designee by 03-15-2011		
		pites/sips, Slow rate,			03-13-2011		
		wallows per bolus."			How the corrective action(s) will	• • • • • • • • • • • • • • • • • • •	
	and manipie s	wallows per colus.			monitored to ensure the deficient		
	The record ind	licated the resident			practice will not recur, i.e., what quality assurance program will be	e put	
		lmitted to the facility			into place?		
	on 2/11/11 foll						
	hospitalization	C			DNS/ADNS/Designee will monit	tor	
	nospitanzation	1011 2/3/11.			residents with diet changes with	,	
	The beautel D	Nigohowaa Cumamamu			Continuous Improvement CQI to for Care Planning Update weekly	• • • • • • • • • • • • • • • • • • •	
	•	Discharge Summary,			4 weeks, then bi-weekly for 4 we	I	
	dated 2/11/11,				and then monthly thereafter. CQI	I	
		l Diagnoses included,			monthly meeting will review result of audit.	ılts	
		mited to, aspiration			or addit.		
	_	lysphagia (difficulty			Date of Compliance: 03/16/201	1	
	• • • • • • • • • • • • • • • • • • • •	niatal hernia with					
	intrathoracic s	*					
	restrictive lung	g disease in					
	association wi	th kyphoscoliosis and					
	hiatal hernia.	The Hospital Course					
	section of the	Discharge Summary					
	indicated, but	was not limited to,					
	"According	to her son, there was					
	concerned [sic] that the diet was not					
	ideal at the ski	lled nursing facility					
		des. After discussion					
	with our dietit	ian and speech					
		patient's son will be					
	1 / 1						

000327

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561			(X2) MUI A. BUILI B. WING	DING	NSTRUCTION	(X3) DATE S COMPL 02/24/2	ETED
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	P. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	discussing the with the admir skilled facility Discharge Inst hospital Disch included, but was "Pureed diet liquids and detand dietary recently enclosed on the formsShe has factors for aspageneral weakndysphagia, the assistance with occasional unincoordination and finally she hiatal hernia, estomach is in his scan from the January and arcould result in stomach conte	specifics on the diet nistrators at the where she resides" ructions on the arge Summary were not limited to, with thickened tailed speech therapy commendations are e transfer as multiple risk iration including her ess, malaise, fact that she requires n meals and the ntentional //or feeding mishap, has a very large essentially her entire ner thorax on the CT last hospitalization in ny degree of reflux aspiration of		TAG	DEPICIENCY)		DATE
	2 01111, 0151104 (and succe of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561				IULTIPLE CO ILDING	NSTRUCTION	C	(X3) DATE SURVEY COMPLETED 02/24/2011	
		100001	B. WI				<u> </u>	
	PROVIDER OR SUPPLIER AMARITAN HOME	& REHABILITATIVE CENTER		231 N J	ADDRESS, CITY, STATE, ZIF ACKSON ST ND CITY, IN47660	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
!	1 1	2/11/11, included, but	ĺ					
		d to, "Diet: pureed						
	nectar thick liquid*Thera	any Sneech:						
	1 *	reat*nectar thick						
		teaspoon offer fluids						
	* -	mbol for hour] while						
	1 .	90 [symbol for						
	1 0 111	bol for with] meals						
	encourage dou	teaspoon small bites						
	1	talking [symbol for						
	1	mouth keep HOB						
	1 -	> [greater than] 30						
		egrees] @ all times						
	chin tuck [sym	nbol for with]						
	swallowing."							
	The resident's	care plan with						
		of Problem/Strength						
		licated, "Risk for						
	1	an update to the						
		igth on 2/11/11						
	· ·	reed diet [symbol for nick fluids. At risk						
		[symbol for with] hx						
	1 ^	ultiple episodes of						
	1 - * -	nterventions, dated						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	N8T311	Facility l	ID: 000327 If o	continuation sheet	Page 7 of 28	

	OF OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL A. BUILDING			ETED	
		155561	B. WIN			02/24/2	UT
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ACKSON ST		
		& REHABILITATIVE CENTER		OAKLA	ND CITY, IN47660		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	2/18/11, indica	nted, "Encourage chin					
	tucks when ea	ting/drinking, HOB					
	[head of bed]	[arrow pointing up]					
	30 [symbol for	r degrees] (at least),					
	Allow sufficie	nt time to swallow,					
	Place small an	nt [amount] of					
	food/fluids on	tip of tongue."					
	Documentation	n failed to indicate all					
	the feeding ted	chniques indicated on					
	the physician's	s discharge orders					
	upon discharge	e from the hospital					
	were included	on the plan of care.					
	A D1	T.1. 1. O.1					
	· *	Telephone Order,					
	· ·	indicated, "S.T.					
	` ^	y) Evaluation for					
	Dysphagia cor	•					
	Pureed w/ [wit	-					
	· ·	iquids S.T. 1 X (one					
		atient] & caretaker					
		n the same document					
		n Update" with Pt. & caretaker					
	SKIIICU S.1. INS	struction for feeding."					
	The CNA Assi	gnment Sheet,					
	received from	the Assistant					
	Director of Nu	rsing, during the					
	L						

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV. COMPLETED D. WING 02/24/2011			ETED	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02,24,2	· · ·
NAME OF I	PROVIDER OR SUPPLIER				ACKSON ST		
		& REHABILITATIVE CENTER		OAKLA	ND CITY, IN47660		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Initial Tour on	2/24/11 at 10:30					
	a.m., indicated	l related to Special					
	Instructions fo	r Resident D:					
	"Extensive ass	sist with adl's					
	[Activities of l	Daily Living],					
	thickened liqu	ids, offer foods and					
	fluids freq. [fr	equently]."					
	The Speech Th	nerapy Plan of					
	Treatment, wit	th "SOC [Start of					
	Care] Date 2/1	1/11 [sic]" indicated					
	in the section '	"Precautions: Hx					
	[history] of as	pirationPosition at					
	90 degree angl	le during and 20					
	minutes after of	oral intake. Utilize					
	chin tuck with	oral intake.					
	Recommended	d liquids consistency					
	is nectar consi	stency by spoon.					
	Recommended	d diet is puree." The					
	"Skilled Servio	ces Completed,"					
	section indicat	ed, "Analyzed					
	family/caretak	er knowledge of					
	feeding. Pt [page 1]	atient] using					
	compensatory	swallow techniques					
	per Dr's [docto	or's] orders and					
	recommendati	ons on 1/26/11 MBS					
	study. Provide	ed skilled instruction					
	for Pt and care	egiver." The plan was					
	<u> </u>						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/24/2011	
		155561	B. WIN			02/24/2	:011
	PROVIDER OR SUPPLIER AMARITAN HOME	& REHABILITATIVE CENTER		231 N J	.ddress, city, state, zip code ACKSON ST ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	electronically Therapist on 2	signed by the Speech /16/11.					
	p.m., the Direct (DON) provided handwritten does the resident's selfacility for inselfacility for inse	bocument she indicated son provided the tructions for feeding he indicated the in the ADL binder NAs for a. She indicated the ion was on the at the foot of ed. undated handwritten wided by the DON ollowing related to ent D: "Must be at 90 [symbol for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/24/2011	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	231 N .	ADDRESS, CITY, STATE, ZIP CODE JACKSON ST AND CITY, IN47660	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	chokes or cough her) to cough her throat before adittional [sic] be awake - ale otherwise she well. She must work on swall and 1/2 hours to tilt head for swalling [sic], the tip of her to swallow. If it her tongue it sand may go in	fluid or food. Must rt to eat or drink - will not swallow st think about and owingAllow 1 - 1 per meal. She need ward to assist in Put food & drink on ongue so she must is put on the back of lides down her throat to her lungs. No hing by spoon."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155561	B. WIN		02/24/2011		
NAME OF I	PROVIDER OR SUPPLIER			STREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				JACKSON ST		
		& REHABILITATIVE CENTER			AND CITY, IN47660		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
F0311		rvation, interview,	F03		F-311 Treatment/Services to		
SS=D		iew, the facility			Improve/Maintain ADLS Wha		
33-D		,			corrective action(s) will be		
		e staff implemented			accomplished for those	_	
	safe feeding te	echniques for food			residents found to have beer affected by the deficient]	
	and beverages	for 1 of 1 resident			practice? Resident D: The Ca	re	
	reviewed relate	ed to a swallowing			Plan has been updated to ens		
		ndividualized feeding			plan of care was coordinated	.	
	techniques in a				among family and staff. Direc Care staff and family were	τ	
	_	sample of 3			immediately in serviced by		
	(Resident D).				Speech Therapist regarding		
					swallowing instructions for		
	Findings inclu	de:			feeding of pureed diet and thickened liquids per MD orde	r	
					How other residents having t		
	During intervi	ew on 2/24/11 at 1:00			potential to be affected by th		
	_	member of Resident			same deficient practice will be	oe	
	1 '				identified and what correctiv		
		e was at the facility			action(s) will be taken? Audit will be completed on all Reside		
	_	rning until night to			to ensure ordered diet is corre		
	feed the reside	ent her meals and			Speech Therapist will in service		
	"keep everythi	ng moving -			Clinical staff on any special		
	-	l, food warm." At			feeding techniques. Audit will	be	
	_	dent D was observed			completed by DNS/ADNS/DESIGNEE BY		
	· ·				03-15-2111 Audit will be		
		edside in a high			completed on Aide Assignmen		
		with a neck pillow in			sheets to ensure ordered diet		
	place. The fan	nily member used			special feeding precautions ar correct. To be completed by		
	small white pla	astic spoons to spoon			DNS/DNS/DESIGNEE BY		
	_	of pureed foods to			03-15-11 What measures will	be	
	the resident. T	_			put into place or what		
					systematic changes will be made to ensure that the		
		e observed to be			deficient practice does not		
	tnickened. Th	e family member			recur?		
	<u> </u>				L	l l	

000327

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLI	ETED
		155561	B. WIN			02/24/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		231 N J	JACKSON ST		
	SAMARITAN HOME	& REHABILITATIVE CENTER		OAKLA	ND CITY, IN47660		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	indicated the regular staff make				DNS,or designee will observe fve random meals per week of tihose		
	sure the reside	ent's foods are pureed			residenti's witih swallowing problen	ns	
	and the care is	s moving. She			and individualized feeding		
	indicated the '	'new ones have to			tiechniques for4 weeks tio monition	r	
					proper feeding tiechniques being		
	1	ant to give her regular			utilized.		
	water with ice	2. "			DNS, or designee will verbally		
					question Nursing personnel on		
	The clinical re	ecord for Resident D			specialized feeding tiechniques fve	.	
	was reviewed	on 2/24/11 at 4:00			times weekly for four weeks and will immediatiely counsel and intiervene		
		011 2/24/11 at 4.00			personnel demonstiraties inadequa		
	p.m.				tiechnique		
					DNS or designee will tihen observe		
	The record inc	dicated the resident			tiwo meals a week for four weeks o		
	was readmitte	d to the facility on			tihose residenti's witih swallowing		
		•			problems and individualized feeding	3	
		ving hospitalization			tiechniques for four weeks tio		
	on 1/22/11 for	diagnoses including,			monitior proper feeding tiechnique		
	but not limited	d to, hypoxia and			DNS or designee will verbally		
	pneumonia	A Speech Pathology			question Nursing Personnel on specialized feeding tiechniques tiwo	,	
	Report of Mod				times weekly for four weeks and wil		
	1 ^				immediatiely counsel and intiervene		
	,	S), dated 1/26/11,			personnel demonstiraties inadequa		
	included, but	was not limited to,			tiechniques		
	"Comments:	Pt [patient] requires			How the corrective action(s)		
	strict adherence				will be monitored to ensure t		
					deficient practice will not rec	cur,	
	_	ninimize risk for			i.e., what quality assurance program will be put into place		
	aspiration."				DNS/ADNS/Designee will mor		
					residents with diet changes wi		
	The record inc	dicated the resident			Continuous Improvement CQI		
		dmitted to the facility			tool for Care Planning Update		
					weekly for 4 weeks, then bi-weekly for 4 weeks and the	<u> </u>	
	on 2/11/11 fol	lowing			monthly thereafter. CQI month		
					mentally are estated a equilibria	,	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		A. BUILDING B. WING			COMPL 02/24/2	ETED	
	ROVIDER OR SUPPLIER		B. WI	STREET A	ADDRESS, CITY, STATE, ZIP CODE IACKSON ST ND CITY, IN47660	1	
	AMARITAN HOME A SUMMARY S' (EACH DEFICIENCE REGULATORY OR hospitalization) The hospital D dated 2/11/11, resident's Fina but were not lipus preumonitis, diswallowing), hintrathoracic strestrictive lung association with hiatal hernia. section of the limiticated, but s'According to concerned [sic ideal at the ski where she resident with our dietitit therapist, the product discussing the with the administilled facility.	REHABILITATIVE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) TO 0 2/3/11. Discharge Summary, indicated the I Diagnoses included, mited to, aspiration dysphagia (difficulty hiatal hernia with tomach, and g disease in th kyphoscoliosis and The Hospital Course Discharge Summary was not limited to, to her son, there was I that the diet was not lled nursing facility des. After discussion ian and speech patient's son will be specifics on the diet mistrators at the where she resides"	B. WI	STREET A	IACKSON ST	I	(X5) COMPLETION DATE
	hospital Disch included, but v	ructions on the arge Summary were not limited to, with thickened					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/24/2011	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	STREET . 231 N .	ADDRESS, CITY, STATE, ZIP CODE JACKSON ST AND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
	and dietary recenclosed on the formsShe has factors for asp general weaking dysphagia, the assistance with occasional unincoordination and finally she hiatal hernia, estomach is in I scan from the January and arcould result in stomach context. The hospital's Form, signed a physician on 2 was not limited nectar thick liquid*There Evaluate and the liq (liquid) by q [every] 2 [sy	as multiple risk iration including her ess, malaise, fact that she requires in meals and the intentional for feeding mishap, whas a very large essentially her entire her thorax on the CT last hospitalization in my degree of reflux aspiration of ints" Continuity of Care and dated by the fill/11, included, but it does not included, but included in the continuity of t				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 02/24/2011	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	231 N	T ADDRESS, CITY, STATE, ZIP COI N JACKSON ST LAND CITY, IN47660	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	small sips by the encourage dour encourage nowith food in the food in the food in the food in the food of the food	talking [symbol for mouth keep HOB > [greater than] 30 egrees] @ all times abol for with] indicated the a.m., "120 ml of quid intake so far this p.m. to 6:00 a.m., ox [sic] y] 360 ml of nectar ais shift" (a.m. or p.m. not ed am [morning] meal				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/24/2011		
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	STREI 231 I	ET ADDRESS, CITY, STATE, ZIP CODE N JACKSON ST LAND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	frequently. W spoonfuls then and take 3 more 2/19/11 0930 (fed res. [reside [morning] [symproblem [symbolem [symbolem [symbolem in and fed the come in a spiral in a s	ould take about 3 a wait a few minutes re" (9:30 a.m.) "CNA ent] this AM mbol for without] bol for with] dsWants family to eed q [every] meal" care plan with f Problem/Strength dicated, "Risk for an update to the gth on 2/11/11 reed diet [symbol for nick fluids. At risk [symbol for with] hx altiple episodes of atterventions, dated ated, "Encourage chin ting/drinking, HOB [arrow pointing up] r degrees] (at least), ant time to swallow,	TAG			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IA (X2	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155561	A. I	BUILDING			02/24/20	
		100001	В. V	WING			02124120	, i i
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STA	ATE, ZIP CODE		
GOOD S	AMARITAN HOME	& REHABILITATIVE CEI	NTER	I	ND CITY, IN476	60		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			1	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY F	TULL	PREFIX	(EACH CORRECTIV	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMAT	ΠΟN)	TAG		ICIENCY)		DATE
		n failed to indicate						
	the feeding tec	chniques indicated of	on					
	the physician's	discharge orders						
	upon discharge	e from the hospital						
	were included	on the plan of care						
	A Physician's	Telephone Order,						
	dated 2/14/11,	indicated, "S.T.						
	(speech therap	y) Evaluation for						
	Dysphagia cor	npleted. Diet:						
	Pureed w/ [wit	th] Nectar -						
	Consistency L	iquids S.T. 1 X (on	e					
	-	atient] & caretaker						
	, -1	n the same docume	nt					
		n Update" with						
	"Intervention I	-						
		struction for feeding	o "					
			5.					
	The CNA Assi	gnment Sheet.						
	received from	•						
		rsing, during the						
		2/24/11 at 10:30						
		related to Special						
	Instructions fo	-						
	"Extensive ass							
	[Activities of I							
	_	ids, offer foods and						
	fluids freq. [fro	equentiyj."						
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Eve	nt ID: N8T3	Facility I	D: 000327	If continuation sh	eet Pac	e 18 of 28

OT OF DEFICIENCIES OF CORRECTION	ECTION IDENTIFICATION NUMBER: A. BUILDING			NSTRUCTION	(X3) DATE COMPI 02/24/2	LETED
PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660	1	
AMARITAN HOME SUMMARYS (EACH DEFICIENT REGULATORY OR PROGULATORY O	REHABILITATIVE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) The rapy Plan of Ith "SOC [Start of I/11 [sic]" indicated 'Plan:" "She has a mily who provides for assist her with Its." The "Skilled Deted," section malyzed er knowledge of atient] using swallow techniques or's] orders and ons on 1/26/11 MBS and skilled instruction regiver." The plan was signed by the Speech I/16/11. The won 2/24/11 at 5:20 and the content of the content o	B. WIN	STREET A			(X5) COMPLETION DATE
techniques. Sl heard the spee	ne indicated she had ch therapist talking to feeding. The DON					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 02/24/2011	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	231 N	FADDRESS, CITY, STATE, ZIP COI JACKSON ST AND CITY, IN47660	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	document she resident's son with instruction feeding instruct the document binder used by documentation same informat overbed table. Resident D's bresident had no plan. Review of the document provincluded the feeding Resident Sitting upright degrees] to ear anythingKe degrees or mo [underlined] lino ice cream per bite of foo 1/2 teaspoon a chokes or cought.	provided the facility ons that included etions. She indicated was in the ADL of the CNAs for on. She indicated the ion was on the eat the foot of ored. She indicated the orestorative feeding undated handwritten wided by the DON ollowing related to ent D: "Must be at 90 [symbol for				

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/24/2011	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME &	REHABILITATIVE CENTER	STREE 231 N	T ADDRESS, CITY, STATE, ZIP CODE N JACKSON ST LAND CITY, IN47660	}		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
her throat before a dittional [sic] if be awake - alert otherwise she well. She must work on swallow and 1/2 hours per to tilt head forw swalling [sic]. It the tip of her to swallow. If it is her tongue it sli and may go into straws. Everyth During interview p.m., the Speech Pathologist indiwith the caregivers.	re giving her fluid or food. Must t to eat or drink - vill not swallow think about and wingAllow 1 - 1 her meal. She need vard to assist in Put food & drink on ngue so she must s put on the back of ides down her throat to her lungs. No hing by spoon." w on 2/24/11 at 6:10 h Language icated she worked ver, but not staff, on ues for Resident D.	IAG			DATE	

i '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155561	B. WING	G		02/24/2011	
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COODS		9 DELIADII ITATIVE CENTED			JACKSON ST IND CITY, IN47660		
		& REHABILITATIVE CENTER			IND CITT, IN47000		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0365	Based on obse	rvation, record	F03	65	F-365 Food in Form to Meet		03/16/2011
SS=D		erview, the facility			Individual Needs.		
	failed to ensur	•			What corrective action(s) will be	e	
	received the te	exture of food ordered			accomplished for those residents		
	by the physicia	an for 1 of 1 resident			found to have been affected by t deficient practice?	he	
		ed to diet texture in a			-		
		sidents (Resident D).			Resident D: The Care Plan has be		
		sidents (resident 2).			updated to ensure plan of care wa coordinated among family and sta		
	Findings inclu	de·			Direct Care staff and family were		
	i mamgs mera				immediately in serviced by Speed Therapist regarding swallowing	ch	
	During intervi	ew on 2/24/11 at 1:00			instructions for feeding of pureed		
	_				diet and thickened liquids per MI		
	_	member of Resident			order.		
		e was at the facility			How other residents having the		
	_	rning until night to			potential to be affected by the		
		ent her meals and			same deficient practice will be identified and what corrective		
	"keep everythi	c c			action(s) will be taken?		
		d, food warm." At					
		dent D was observed			Audit will be completed on all Residents to ensure ordered diet i	c	
		edside in a high			correct. Speech Therapist will in	J	
		with a neck pillow in			service Clinical staff on any speci		
	place. The far	mily member used			feeding techniques that is identifi with audit. Audit will be comple		
	small white pla	astic spoons to spoon			by DNS/ADNS/DESIGNEE BY	ieu	
	small amounts	of pureed foods to			03-15-211.		
	the resident. T	The resident's			Audit will be completed on Aide		
	beverages wer	e observed to be			Assignment sheets to ensure orde	red	
	thickened. Th	e family member			diet and special feeding precautio	ons	
		egular staff make			are correct. To be completed by DNS/ADNS/DESIGNEE BY		
		ent's foods are pureed			03-15-11.		
		1					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155561	B. WIN			02/24/20	11
NAME OF I	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
	AMARITAN HOME	& REHABILITATIVE CENTER		l	ACKSON ST ND CITY, IN47660		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION DATE
1.10	and the care is				What measures will be put into		2.112
		new ones have to			place or what systematic change	es	
	l				will be made to ensure that the		
	I -	ant to give her regular			deficient practice does not recur Clinical Nurses/Speech Therapist		
	l	." She indicated the			will be in serviced to notify Spee		
	· -	eemed to be doing			Therapy and Dietary of all diets u		
		ending pureed foods			Admission, readmission and char in condition. In service to be	ige	
		chanical soft foods for			completed by DNS/ADNS/Desig	nee	
	the resident's i	neals.			by 03-15-2011		
	was reviewed p.m. The record incompass readmitted 1/31/11 follow on 1/22/11 for but not limited pneumonia. A Report of Mod Swallow (MB included, but we "Comments: I strict adherence strategies to ma aspiration."	S), dated 1/26/11, was not limited to, Pt [patient] requires			IDT team to ensure that special dor residents with special feeding precautions are communicated to Speech Therapy and dietary will review all New Admissions and Readmits/residents with change is condition. Care Plan will be updated and Aide Assignment Sh will be updated at that time. More IDT Clinical meeting. Clinical Nurses/Speech Therapist will be in serviced to notify Speech Therapy and Dietary of all diets to admission, readmission and changin condition. In service to be completed by DNS/ADNS/Desig by 03-15-2011 Speech Therapist/Designee will inservice Clinical Staff upon Admission/readmission/change in condition on special feeding precautions and special diet to ensafety and special precautions are followed. To be completed by 03-15-2011	n eets ning ch upon ge nee	
	The record file	neated the resident			03-13-2011		
	l						

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	NG COMPLETED		
		155561	B. WIN			02/24/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER		1	JACKSON ST IND CITY, IN47660		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	1	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
	was again reac	lmitted to the facility			How the corrective action(s) wil	1	
	on 2/11/11 foll	lowing			be monitored to ensure the deficient practice will not recur.		
	hospitalization	on $2/3/11$.			i.e., what quality assurance		
	1				program will be put into place?		
	The hospital D	Discharge Summary,			DNS/ADNS/Designee will monit	or	
	dated 2/11/11,	- · · · · · · · · · · · · · · · · · · ·			residents with specific diet chang	es	
	•	l Diagnoses included,			with Continuous Improvement Cotool for Meal Service Observation	· .	
		mited to, aspiration			weekly for 4 weeks, then bi-week		
		lysphagia (difficulty			for 4 weeks and then monthly		
	_	niatal hernia with			thereafter. To be completed by DNS/ADNS/Designee		
	intrathoracic s				CQI monthly meeting will review	7	
	restrictive lung				results of audit monthly.		
	_	th kyphoscoliosis and			IDT team will bring results to CQ	ni	
					committee for review; overseen b		
		The Hospital Course			Executive Director.		
		Discharge Summary			Date of Compliance: 03/16/2011		
	· ·	was not limited to,			Date of Comphanee. 05/10/2015	`	
	_	to her son, there was					
		t] that the diet was not					
		illed nursing facility					
		des. After discussion					
		ian and speech					
		patient's son will be					
	_	specifics on the diet					
	with the admir	nistrators at the					
	skilled facility	where she resides"					
	Discharge Inst	ructions on the					
	hospital Disch	arge Summary					
					l .		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING			02/24/2011		
NAME OF PROMISER OF CAMPAGE			D. WII		ADDRESS, CITY, STATE, ZIP CODE	ļ		
NAME OF PROVIDER OR SUPPLIER				1	ACKSON ST			
GOOD SAMARITAN HOME & REHABILITATIVE CENTER				OAKLA	ND CITY, IN47660			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	included, but v	were not limited to,						
	"Pureed diet	with thickened						
	liquids and det	tailed speech therapy						
	and dietary recommendations are							
	enclosed on th	e transfer						
	formsShe ha	as multiple risk						
	factors for asp	iration including her						
	general weakn	ess, malaise,						
	dysphagia, the	fact that she requires						
	assistance with	n meals and the						
	occasional uni	ntentional						
	incoordination	or feeding mishap,						
	and finally she	e has a very large						
	hiatal hernia, e	essentially her entire						
	stomach is in l	ner thorax on the CT						
	scan from the	last hospitalization in						
	January and any degree of reflux							
	could result in aspiration of							
	stomach contents"							
	1	Continuity of Care						
	, ,	and dated by the						
	physician on 2	/11/11, included, but						
		d to, "Diet: pureed						
	nectar thick							
	liquid*Thera							
	Evaluate and t	reat*nectar thick						
	liq (liquid) by	teaspoon offer fluids						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155561		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/24/2011		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN47660				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE	
	q [every] 2 [sy awake upright degrees] [sym small sips by the encourage down encourage not with] food in the facility's It is facility is facility in the facility's It is facility in the section is facility in the section is facility. The Diet Compared in the facility is facility in the facility in the facility is facility in the facility is facility in the facility in the facility is facility in the facility in the facility is facility in the facility in the facility in the facility in the facility is facility in the facility in the facility in the facility is facility in the fa	rmbol for hour] while 90 [symbol for bol for with] meals reaspoon small bites able swallow talking [symbol for mouth keep HOB > [greater than] 30 regrees] @ all times					

000327

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/24/2011	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	· ·	check boxes for					
		oft, Pureed, Finger					
	Foods, and Oth	the blank line next					
		was "Dysphagia."					
		was Dyspiiagia.					
	During intervi	ew on 2/24/11 at 5:45					
	_	ctor of Nursing					
	(DON) indicat	· ·					
	consider a dys	phagia diet to be a					
	mechanical so	ft diet. During					
	interview at th	is same time, the					
	facility's Cons	ultant Dietary					
	Manager refer	enced the facility's					
	current Indiana	a Diet Manual, dated					
	2011. She prov	vided copies of pages					
	307 through 3	12 which described					
	•	and preparation					
		e dysphagia diets.					
		the resident had					
	previously bee						
		t, and when dietary					
		eiet Communication					
	Form for Dysp	•					
	, and the second second	evel 2 had been					
		2/14/11 when the					
		der was changed to a					
	pureed diet, w	hich she indicated					

l	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 02/24/2011	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER			231 N .	ADDRESS, CITY, STATE, ZIP CODI JACKSON ST AND CITY, IN47660	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	diet. She indicated documentation resident would Level 2 (mech						